		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027490

Facility Name: MANORCARE AT KANKAKEE

Address: 900 West River Place (Number) Kankakee (City) 60901 (Zip Code)

County:

Telephone Number: (815) 966-1711 **Fax #** (815) 933-2065

IDPA ID Number: 520886946003

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/01 to 05/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President - Reimbursement

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	107	Skilled (SNF)	107	39,055	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	107	TOTALS	107	39,055	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,543	2,099	7,389	12,031	8
9	SNF/PED					9
10	ICF	16,475	5,780	744	22,999	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,018	7,879	8,133	35,030	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.69%

D. How many bed-hold days during this year were paid by Public Aid?
321 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 39 and days of care provided 6,963

Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/02 Fiscal Year: 05/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	158,802	15,470	8,393	182,665	1,101	183,766		183,766			1
2	Food Purchase		134,693		134,693		134,693	(2,234)	132,459			2
3	Housekeeping	68,206	9,012		77,218		77,218		77,218			3
4	Laundry	36,546	9,443	393	46,382		46,382		46,382			4
5	Heat and Other Utilities			91,419	91,419	5,234	96,653		96,653			5
6	Maintenance	30,273	24,338	14,792	69,403		69,403		69,403			6
7	Other (specify):* Med Waste			488	488		488		488			7
8	**TOTAL General Services**	293,827	192,956	115,485	602,268	6,335	608,603	(2,234)	606,369			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,359,797	134,421	16,044	1,510,262	25,482	1,535,744		1,535,744			10
10a	Therapy	191,285	2,425	14,649	208,359		208,359		208,359			10a
11	Activities	48,687	2,395	4,113	55,195	2,684	57,879		57,879			11
12	Social Services	45,357			45,357		45,357		45,357			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,645,126	139,241	43,206	1,827,573	28,166	1,855,739		1,855,739			16
	C. General Administration											
17	Administrative	72,227		275,671	347,898	(131,850)	216,048		216,048			17
18	Directors Fees											18
19	Professional Services			12,517	12,517	(4,648)	7,869	(7,869)				19
20	Dues, Fees, Subscriptions & Promotions			34,728	34,728		34,728	(17,726)	17,002			20
21	Clerical & General Office Expenses	142,508	35,002	68,452	245,962	1,458	247,420	(50,625)	196,795			21
22	Employee Benefits & Payroll Taxes			444,985	444,985	8,100	453,085		453,085			22
23	Inservice Training & Education			3,214	3,214		3,214		3,214			23
24	Travel and Seminar			9,312	9,312		9,312		9,312			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			70,055	70,055		70,055		70,055			26
27	Other (specify):*			1,458	1,458	(1,458)						27
28	**TOTAL General Administration**	214,735	35,002	920,392	1,170,129	(128,398)	1,041,731	(76,220)	965,511			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,153,688	367,199	1,079,083	3,599,970	(93,897)	3,506,073	(78,454)	3,427,619			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MANORCARE AT KANKAKEE #0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			210,112	210,112	28,079	238,191		238,191			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					65,818	65,818	(556)	65,262			32
33	Real Estate Taxes			46,753	46,753		46,753	999	47,752			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			38,643	38,643		38,643		38,643			35
36	Other (specify):*											36
37	**TOTAL Ownership**			295,508	295,508	93,897	389,405	443	389,848			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		186,155	14,803	200,958		200,958		200,958			39
40	Barber and Beauty Shops	4,160	8,747	3,864	16,771		16,771		16,771			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,584	58,584		58,584		58,584			42
43	Other (specify):*		51,790		51,790		51,790		51,790			43
44	**TOTAL Special Cost Centers**	4,160	246,692	77,251	328,103		328,103		328,103			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,157,848	613,891	1,451,842	4,223,581		4,223,581	(78,011)	4,145,570			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (670)	21	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,234)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,981)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(556)	32		10
11	Discounts, Allowances, Rebates & Refunds	(105)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,414)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(3,954)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,869)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(41,501)	21		24
25	Fund Raising, Advertising and Promotional	(17,726)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	999	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (78,011)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (78,011)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

MANORCARE AT KANKAKEE

ID# 0027490

Report Period Beginning: 06/01/01

Ending: 05/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$ 0		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,234)	0	0	0	0	0	0	0	0	0	0	(2,234)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,234)	0	0	0	0	0	0	0	0	0	0	(2,234)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,869)	0	0	0	0	0	0	0	0	0	0	(7,869)	19
20	Fees, Subscriptions & Promotions	(17,726)	0	0	0	0	0	0	0	0	0	0	(17,726)	20
21	Clerical & General Office Expenses	(50,625)	0	0	0	0	0	0	0	0	0	0	(50,625)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(76,220)	0	0	0	0	0	0	0	0	0	0	(76,220)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(78,454)	0	0	0	0	0	0	0	0	0	0	(78,454)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(556)	0	0	0	0	0	0	0	0	0	0	(556)	32
33	Real Estate Taxes	999	0	0	0	0	0	0	0	0	0	0	999	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	443	0	0	0	0	0	0	0	0	0	0	443	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(78,011)	0	0	0	0	0	0	0	0	0	0	(78,011)	45

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH.			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 275,671	HCR Manor Care, Inc.	100.00%	$ 275,671	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	13,000	Heartland Management Services	100.00%	13,000		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 288,671			$ 288,671	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc.
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH. 43604
Phone Number: (419)252-5500
Fax Number: (419)254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	$	$	3,921,910	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	680,609	406,990	3,921,910	1,101	2
3	5	Utilities - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	154,435		3,921,910	299	3
4	5	Utilities - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	3,051,710		3,921,910	4,935	4
5	10	Nursing - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	10,993,908	7,606,940	3,921,910	21,273	5
6	10	Nursing - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	1,902,166	1,264,589	3,921,910	3,076	6
7	17	General & Admin - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	14,112,784	11,038,075	3,921,910	27,308	7
8	17	General & Admin - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	71,533,109	46,622,737	3,921,910	115,683	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	2,156,484		3,921,910	4,173	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	2,428,174		3,921,910	3,927	10
11	30	Depreciation - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	101,489		3,921,910	196	11
12	30	Depreciation - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	17,241,472		3,921,910	27,883	12
13										13
14	32	Interest				65,818			65,818	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 124,422,158	$ 66,939,331		$ 275,671	25

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Conv. Sub. Debentures		X				$ 844,222	$ 844,222			$ 65,818	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8								Interest Income			(556)	8
9	TOTAL Facility Related						$ 844,222	$ 844,222			$ 65,262	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 844,222	$ 844,222			$ 65,262	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 45,754	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 46,753	2
3. Under or (over) accrual (line 2 minus line 1).		$ 999	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 46,753	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 47,752	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	46,761	8
	1998	45,947	9
	1999	45,754	10
	2000	45,754	11
	2001	46,753	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MANORCARE AT KANKAKEE COUNTY

FACILITY IDPH LICENSE NUMBER 0027490

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-09-31-412-001	See Attached	$ 47,412.12	$ 47,412.12
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 47,412.12	$ 47,412.12

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,938 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1981	$ 29,077	1
2					2
3	TOTALS			$ 29,077	3

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88			1969	$ 566,769	$ 49,868		$ 49,868	$	$ 817,970	4
5	9			1988	533,782						5
6	10			1990	60,931						6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS (Current Year Depreciation)					111,020		111,020		1,033,221	9
10				1980	14,866						10
11				1981	90,159						11
12				1982	16,908						12
13				1983	11,723						13
14				1985	33,632						14
15				1987	56,199						15
16				1988	65,707						16
17				1989	92,574						17
18				1990	34,128						18
19				1991	13,615						19
20				1992	46,361						20
21				1993	359,644						21
22				1994	26,647						22
23				1995	21,784						23
24				1995	64,100						24
25	CORRIDOR UPGRADE			1996	4,830						25
26	PROFESSIONAL FEES			1996	2,444						26
27	CARPET & INSTALLATION			1996	2,647						27
28	CAPITALIZED LABOR			1996	7,272						28
29	KITCHEN REMODELING			1996	6,000						29
30	BUILDING UPGRADE			1996	2,362						30
31	REPLACE HEATER TANK			1996	3,921						31
32	NURSE CALL STATION			1996	26,843						32
33	GAS REGULATOR /VALVES			1996	1,104						33
34	INSTALL SMARTLOC			1996	2,793						34
35	INSTALL KITCHEN HOOD SYSTEM			1996	11,690						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PLUMBING/SPRINKLER SYSTEM	1996	$ 7,061	$		$	$	$	37
38	EMERGENCY POWER UPGRADE	1996	3,860						38
39	CARPET/WALLCOVERINGS	1996	1,730						39
40	NURSE CALL SYSTEM	1996	2,295						40
41	DECKING/LANDSCAPING	1996	6,811						41
42	CORPORATE OVERHEAD	1997	10,515						42
43	PLUMBING/SPRINKLER SYSTEM	1997	2,271						43
44	TILE & INSTALLATION	1997	2,911						44
45	WALLVINYL/PAINTING	1997	12,873						45
46	INSTALL CARPET	1997	1,790						46
47	FRONT ENTRY REMODEL	1997	6,068						47
48	ROOF WORK	1997	1,927						48
49	RETIREMENTS	1987	(30,337)						49
50	RETIREMENTS	1992	(5,120)						50
51	ELECTRICAL/LIGHTING	1997	10,539						51
52	REPLACE CEILING	1997	22,190						52
53	WALLVINYL/SUITE SIGNS	1997	3,465						53
54	FACILITY PLAN ALLOC.	1997	5,964						54
55	HVAC/EXHAUST SYSTEM	1997	57,390						55
56	BALLUSTERS & TUBES	1997	5,000						56
57	PLUMBING	1997	1,419						57
58	PAINTING	1997	3,782						58
59	ELECTRICAL	1998	6,739						59
60	DOORS & FRAMES/WINDOWS	1998	8,286						60
61	MASONRY WORK	1998	4,000						61
62	DRYWALL/FINISHES	1998	7,000						62
63	WALLVINYL	1998	2,211						63
64	CORPORATE OVERHEAD	1998	1,651						64
65	FIRE ALARM INSTALL	1998	20,198						65
66	GENERAL CONTRACTOR FEES	1998	3,000						66
67	INTERIOR DEMOLITION/FLOORING & CEILING	1998	3,390						67
68	CARPETING	1998	1,169						68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,373,483	$ 160,888		$ 160,888	$	$ 1,851,191	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,373,483	$ 160,888		$ 160,888	$	$ 1,851,191	1
2	ELECTRICAL/LIGHTING	1998	149						2
3	PAINTING/WALLCOVERING	1998	552						3
4	GENERAL CONTRACTOR FEES	1998	2,507						4
5	SIGNAGE	1998	11,862						5
6	HVAC	1998	3,135						6
7	LANDSCAPING	1998	4,950						7
8	PAINTING/WALLCOVERING	1999	819						8
9	SIGNAGE	1999	1,725						9
10	SECURE CARE SYSTEM	1999	1,278						10
11	COMPRESSOR CHILLER	1999	6,505						11
12	PAGER/SPEAKER SYSTEM	1999	3,900						12
13	NEW DOOR FRAME	1999	1,581						13
14	HOT WATER COMPRESSOR	1999	45,135						14
15	CARPENTRY & ROOFING	2000	148,331						15
16	CARPETING & PADS	2000	12,448						16
17	WALLCOVERING	2000	48,471						17
18	DEVELOPERS COST - ARCADIA DINING	2000	38,406						18
19	BORDER	2000	134						19
20	WALLVINYL - ARCADIA DINING	2000	819						20
21	WALLCOVERING	2000	156						21
22	PAINTING/WALLCOVERING - ARCADIA DINING	2000	3,410						22
23	CARPET	2000	188						23
24	2 A/C UNIT	2001	1,431						24
25	INSTALL SPRINKLER SYSTEM	2001	2,465						25
26	DRAPES	2001	1,520						26
27	DOORS	2001	1,056						27
28	FREIGHT ON WALLCOVERINGS	2001	205						28
29	VWC	2001	5,136						29
30	NEW LANDSCAPING	2001	9,200						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,730,959	$ 160,888		$ 160,888	$	$ 1,851,191	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 514,943	$ 49,224	$ 49,224	$		$ 375,200	71
72	Current Year Purchases	64,418						72
73	Fully Depreciated Assets							73
74	H/O Allocation			28,079	28,079			74
75	TOTALS	$ 579,361	$ 49,224	$ 77,303	$ 28,079		$ 375,200	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,339,397	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 210,112	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 238,191	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 28,079	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,226,391	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 38,643 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	4497	hrs	$ 95,569	202	$ 5,042	$ 1,950	4,699	$ 102,561	1
2	Licensed Speech and Language Development Therapist	10a	922	hrs	19,590	89	2,213	0	1,011	21,803	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	3582	hrs	76,126	296	7,394	475	3,878	83,995	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39,Col.2		# of prescrpts				186,155		186,155	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): P/S Pharm,X-Ray,Lab	10,39 Col.3					14,803			14,803	13
14	TOTAL				$ 191,285	586	$ 29,452	$ 188,580	9,587	$ 409,317	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MANORCARE AT KANKAKEE **#** 0027490 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 05/31/02 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,521	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (106,524))	857,572		3
4	Supply Inventory (priced at)	12,196		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,413		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 879,702	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	29,077		13
14	Buildings, at Historical Cost	2,730,959		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	579,361		16
17	Accumulated Depreciation (book methods)	(2,226,391)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,113,006	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,992,708	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 15,078	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	238,096		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,753		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	47,441		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 347,368	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 347,368	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,645,340	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,992,708	$	48

***(See instructions.)**

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,750,899	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,750,899	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	746,179	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 746,179	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(851,738)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (851,738)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,645,340	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,812,845	1
2	Discounts and Allowances for all Levels	(715,622)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,097,223	3
	B. Ancillary Revenue		
4	Day Care	670	4
5	Other Care for Outpatients		5
6	Therapy	580,165	6
7	Oxygen	144	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 580,979	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,916	12
13	Barber and Beauty Care	15,439	13
14	Non-Patient Meals	475	14
15	Telephone, Television and Radio	2,981	15
16	Rental of Facility Space		16
17	Sale of Drugs	183,906	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,324	19
20	Radiology and X-Ray		20
21	Other Medical Services	29,926	21
22	Laundry	11,140	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 291,107	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	68	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 68	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	383	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 383	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,969,760	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	602,268	31
32	Health Care	1,827,573	32
33	General Administration	1,170,129	33
	B. Capital Expense		
34	Ownership	295,508	34
	C. Ancillary Expense		
35	Special Cost Centers	328,103	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,223,581	40
41	**Income before Income Taxes (line 30 minus line 40)****	746,179	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 746,179	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,898	2,089	$ 51,833	$ 24.81	1
2	Assistant Director of Nursing	3,521	3,875	82,867	21.39	2
3	Registered Nurses	13,713	15,090	271,224	17.97	3
4	Licensed Practical Nurses	17,290	19,026	272,323	14.31	4
5	Nurse Aides & Orderlies	68,312	75,173	661,817	8.80	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	8,340	9,000	191,285	21.25	7
8	Rehab/Therapy Aides					8
9	Activity Director	5,313	5,853	48,687	8.32	9
10	Activity Assistants					10
11	Social Service Workers	3,050	3,323	45,357	13.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,067	21,031	158,802	7.55	15
16	Dishwashers					16
17	Maintenance Workers	2,022	2,226	30,273	13.60	17
18	Housekeepers	8,431	9,287	68,206	7.34	18
19	Laundry	4,554	5,012	36,546	7.29	19
20	Administrator	2,476	2,080	72,227	34.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,108	10,447	142,508	13.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,931	2,128	19,733	9.27	31
32	Other Health Care(specify)					32
33	Other(specify) Beauty&Barber	192	228	4,160	18.25	33
34	TOTAL (lines 1 - 33)	169,218	185,868	$ 2,157,848 *	$ 11.61	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	8,400	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,574	5,10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 13,974		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	N/A	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Lucas	Administrator	0	$ 72,227
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,227

B. Administrative - Other

Description	Amount
Home Office Allocation	$ 275,671
TOTAL (agree to Schedule V, line 17, col. 3)	$ 275,671
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal fees		$ 7,869
Weissman Group	Human Resource	831
Mid America HC	Activity/Soc Srv	2,684
Christine Toolan, RHIA	Med Records	1,133
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 12,517

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 104,797
Unemployment Compensation Insurance	24,810
FICA Taxes	151,744
Employee Health Insurance	144,898
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	569
Payroll Overhead Allocated	
401K / SMSP	15,701
Other Employee Benefits	1,626
Employee Uniforms	840
Home Office Allocation	8,100
TOTAL (agree to Schedule V, line 22, col.8)	$ 453,085

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 100
Advertising: Employee Recruitment	10,924
Health Care Worker Background Check	
(Indicate # of checks performed 78)	1,560
Dues & Subscriptions	940
Association Dues	5,064
Advertising	15,989
Public Relations	151
Less: Non-Allowable Assoc Dues	(1,586)
Less: Public Relations Expense	(151)
Non-allowable advertising	(15,989)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,002

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	9,312
Includes travel expense to the Home	
Office in Toledo, OH for regional	
meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,312

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MANORCARE AT KANKAKEE # 0027490 Report Period Beginning: 06/01/01 Ending: 05/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
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17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MANORCARE AT KANKAKEE **#** 0027490 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $5,064**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,624** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **58,584**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(475)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.